

CHAPTER III

External / Internal Assessment

External Assessment

The Texas Department of Health's (TDH) external assessment identifies issues critical to the future of the agency. Throughout this chapter the economic, social, and political changes taking place in the realm of Texas public health are examined. These trends in the external environment support and guide the development of agency goals, objectives and strategies. The success of public health in Texas depends on its ability to predict, strategize around and impact the trends in the larger environment. Issues considered in the external environment include:

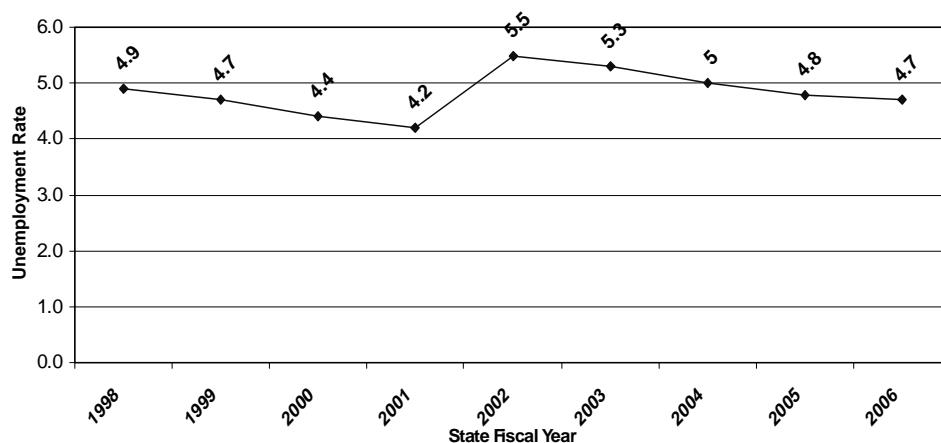
- Economic indicators;
- Demographic trends;
- Health status profile; and
- State and federal health related legislation.

Economic Factors

Combined with the downturn in computer related industries, the economic outlook is less bright than two years ago. The United States economy had its slowest rate of growth in eight years in the second quarter of 2001. Texas has been in the enviable position of being able to weather the economic slowdown better than the nation as a whole, although this has not been uniform across the state. For example, year-to-year employment growth in Texas dropped from four percent for fiscal year (FY) 1998 to a projected 1.6 percent for FY 2002.¹ In contrast, nationwide figures show that employment growth has nearly come to a standstill, dropping over two points to 0.3 percent during the same period.² Current economic indicators provided by the Texas Comptroller of Public Accounts show that the Texas economy has weakened but is still growing, even though the state is currently showing a loss of employment opportunities in the apparel, transportation, equipment, semiconductors, personal computers and telecommunications equipment industries.³

Unemployment in Texas, as for the rest of the nation, has risen significantly (see Figure 3.1). The seasonally adjusted unemployment rate in Texas for December of 2001 was 5.7 percent.⁴ The national seasonally adjusted unemployment rate⁵ for the same period was 5.8 percent.⁶ Current projections show that the unemployment rate for Texas during FY2002 is expected to average 5.5 percent and then slowly decline to 4.7 percent by 2006.⁷

**Figure 3.1 Texas Unemployment Rate by State Fiscal Year:
1998-2006**



Source: Texas Work Force Commission, "Current Unemployment Rates – December 2001." February 2002.

While the statewide unemployment rate is relatively low, some regions of Texas are still experiencing double-digit rates of unemployment. The Texas Workforce Commission's November 2001 estimates show that unemployment rates ranged from a low of 0.8 percent in Collingsworth County to a high of 19.9 to 23.7 percent in Presidio, Starr and Maverick counties.⁸

Among the 11 Health and Human Services (HHS) regions there are significant differences in unadjusted unemployment rates across the state (see Table 3.1). The unadjusted rates for HHS administrative regions range from 2.8 percent for Region 1 (High Plains/Panhandle) to 8.9 percent for Region 10 (Lower Rio Grande

**Table 3.1 Unadjusted Unemployment Rates by Texas
Health and Human Services Administrative Regions,
December 2001**

HHS Region	Unadjusted Unemployment Rate	Variance from State Average
1 – High Plains	2.8%	-2.3%
2 – Northwest Texas	3.4%	-1.6%
3 – Metroplex	5.3%	0.3%
4 – Upper East Texas	5.1%	0.1%
5 – Southeast Texas	6.5%	1.4%
6 – Gulf Coast	4.5%	-0.5%
7 – Central Texas	4.1%	-1.0%
8 – Upper South Texas	4.6%	-0.5%
9 – West Texas	3.7%	-1.4%
10 – Upper Rio Grande	7.2%	2.2%
11 – Lower Rio Grande	8.9%	3.8%
State Unadjusted UE	5.1%	

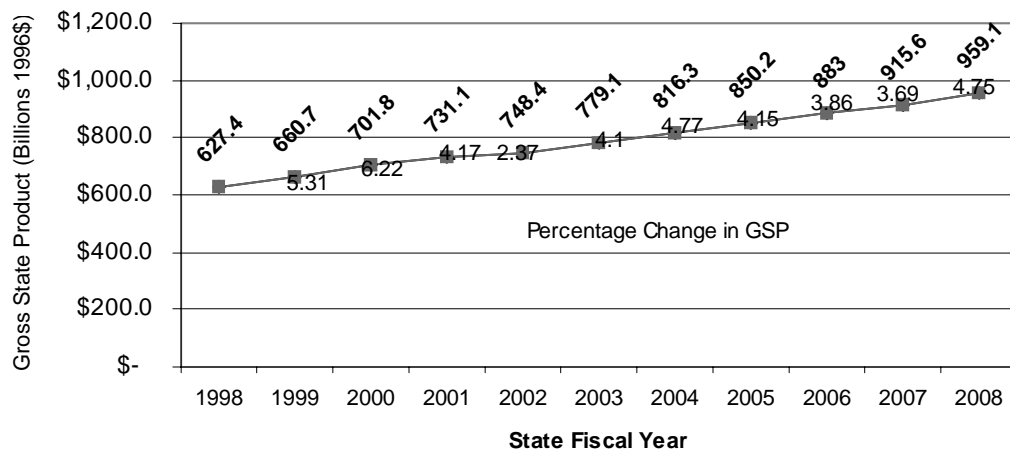
Source: Texas Workforce Commission, February 2002.

Valley). The regions with the highest concentration of population (2, 6, and 7) for the most part mirrored the Texas average. The areas with the most significant problems associated with high unemployment rates remain those along the Texas-Mexico border and the “Golden Triangle” area in the southeast.

A bright spot for Texans amid news of a national recession is the fact that the Texas economy is outperforming the national economy in many areas. Manufacturing employment is down over the year in Texas, but there are expected gains in mining, construction, transportation, wholesale and retail trade, financial, insurance, real estate, and service and government industries, which will help offset the loss. In October 2001, Texas’ annual job growth rate was 1.4 percent, compared to a national job growth rate of -0.3 percent. Texas added 136,800 jobs over the year ending in October, while the nation lost jobs.⁹

The Texas Gross State Product (GSP), the monetary value of all goods and services produced, is expected to rise during the next year, but at a much slower rate (see Figure 3.2). After growing by 6.2 percent between 1999 and 2000, the rate is expected to decrease to 4.2 percent for 2001 and a still smaller increase of 2.4 percent for 2002. The years following will see a gradual growth in GSP in the range of 3.7 to 4.8 percent.¹⁰

Figure 3.2: Texas Gross State Product Forecast and Percentage Change for State Fiscal Years 1998-2008



Source: Texas Comptroller of Public Accounts, “Fall 2001 Fiscal Year Forecast.” Spread sheet. Fall 2001.

Consumer Price Index

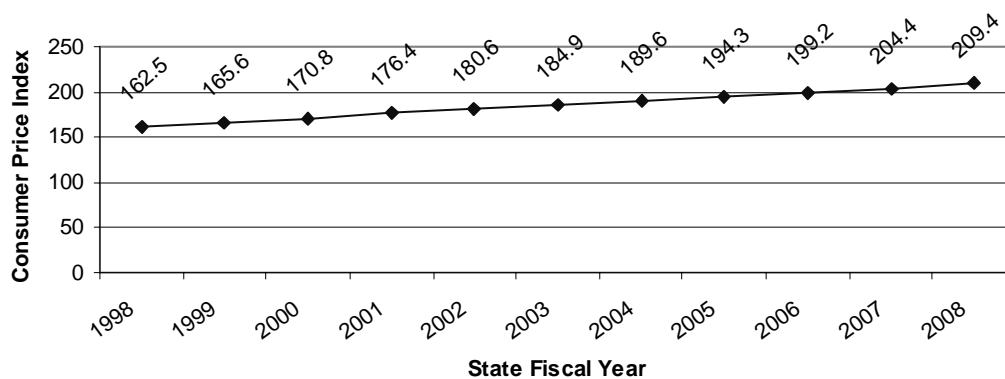
The Consumer Price Index (CPI) measures the average change in prices of goods and services purchased by urban consumers, describing shifts in the purchasing power of the consumer’s dollar. The CPI is based on a sample of prices of food, clothing, shelter and fuel, transportation, medical services, and other goods and services purchased by people for day-to-day living.¹¹

According to the Texas Comptroller of Public Accounts, the Texas CPI has been growing at a slow rate and is not expected to increase dramatically over the next 6 years. After experiencing extremely low rates of growth of less than 2 percent between 1998 and 1999, the rate of growth nearly doubled during 2000 and 2001 to 3.2 and 3.3 percent respectively (see Figure 3.3).

Current Poverty Rates

Poverty is often associated with increased health risks. According to the Current Population Survey, March Supplement 2001, the poverty rate for Texans is 14.7 percent.¹² The U.S. Census defines poverty as having a yearly income of \$17,650 for a family of four (add \$3,020 for each additional person).¹³

**Figure 3.3 Texas Consumer Price Index
by State Fiscal Year 1998-2008**



Source: Texas Comptroller of Public Accounts, "Fall 2001 Fiscal Year Forecast." Spread sheet. Fall 2001.

There remains a significant variation in poverty rates by age, region and ethnicity in Texas. The 17 and under age group remains, proportionately, the largest group in poverty. Table 3.2 shows the difference in poverty rates by age group. In 2000, while 14.7 percent of the total population was classified as "in poverty", 20.9 percent of those aged 17 and under lived at or under the poverty level. People aged 65 and older had 13.2 percent of their population living in poverty while 12.0 percent of adults aged 18 to 64 lived in poverty.¹⁴

Table 3.2 Texas Poverty Rates by Age Group

	00-17	18-64	65+	Total
Percent Less than 100% Poverty	20.9	12.0	13.2	14.7

Source: Current Population Survey, March Supplement 2001

Hispanic and African-American groups continue to represent a disproportionate number of those Texans living under poverty conditions. Table 3.3 shows the differences in poverty rates by race/ethnicity in 1990 and 2000.

The latest data available indicate that a higher percentage of African-Americans (24.3%) and Hispanics (23.0%) than Anglos (7.6%) are living at or below poverty.¹⁵

**Table 3.3 Texas Poverty Rates by Race/Ethnicity
in 1990 and 2000**

	1990*	2000**
Anglo	9.5	7.6
African-American	30.9	24.3
Hispanic	33.0	23.0
Total	18.1	14.7

Source: *STF3A data from the 1990 Census

**Current Population Survey, March Supplement 2001

End Notes

1. “Texas Nonfarm Employment Detail: Fiscal Years 1971 To 2026.” Spreadsheet from Carole Keeton Rylander, Texas Comptroller of Public Accounts. Fall 2001.
2. “The Texas Economic Update: A look at Economic Issues Affecting Texas and the U.S.” Carole Keeton Rylander, Texas Comptroller of Public Accounts. Fall 2001.
3. Ibid.
4. “Texas and U.S. Unemployment Rates: October 2001.” Texas Work Force Commission Web Site. Available at <http://www.twc.state.tx.us/lmi/lfs/type/unemployment/>. Accessed in March 2002.
5. The Texas Workforce Commission adjusts the statewide unemployment rates to reflect seasonal, weather related and regional variations in employment in order to provide more accurate labor market information. Unadjusted rates are the raw numbers of the total number of people in the workforce and the total claiming unemployment. Please see “Seasonality in Texas” at <http://www.twc.state.tx.us/lmi/publications/tlmr/tlmr9710.html> for a more in depth explanation.
6. U.S. Department of Labor, Bureau of Labor Statistics. “U.S. Economy at a Glance.” February 2002. Available at BLS Web Site: <http://stats.bls.gov/eag/eag.us.htm>. Accessed on March 4, 2002.
7. “Fall 2001 Fiscal Year Forecast.” Spread sheet provided by Carole Keeton Rylander, Texas Comptroller of Public Accounts.
8. “Current Unemployment Rates – December 2001.” Texas Work Force Commission Web Site. <http://www.twc.state.tx.us/lmi/lfs/type/unemployment/> Accessed in February 2002.
9. Texas Workforce Commission “Monthly Labor Market Review,” October 2001, p. 4. <http://www.twc.state.tx.us/lmi/publications/tlmr/tlmr0110.pdf>
10. “Fall 2001 Fiscal Year Forecast.” Spread sheet provided by Carole Keeton Rylander, Texas Comptroller of Public Accounts.
11. “Consumer Price Index and Cost of Living Statistics – U.S.” Roberts Dictionary of Industrial Relations, 4th edition. MIT Libraries, Dewey Library. June 1999. Available at <http://libraries.mit.edu/dewey/cpi.html>. Accessed in December 2001.

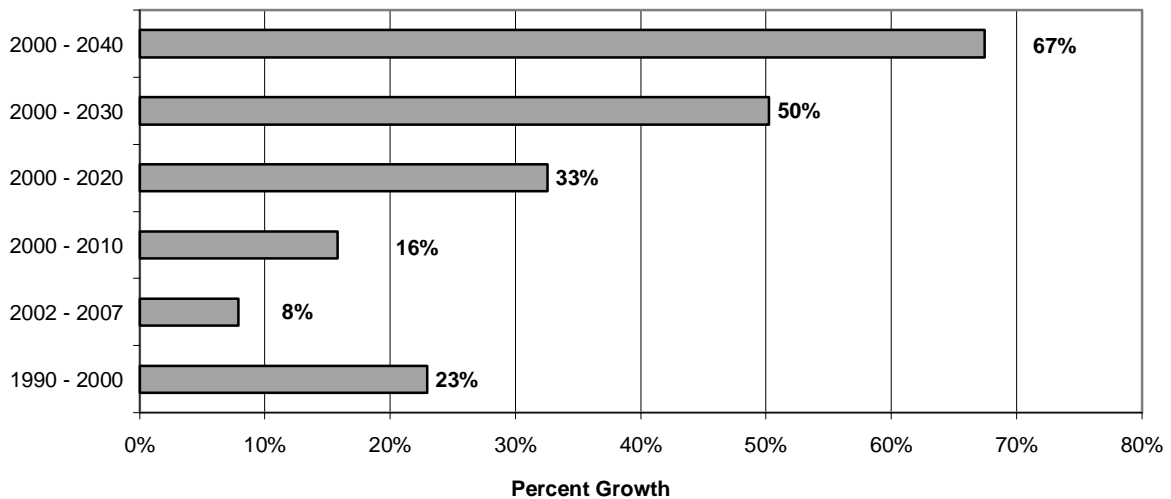
12. Current Population Survey, “March Supplement 2001.” Prepared by Texas Department of Health, Office of Health Information Analysis.
13. Federal Register, Vol. 66, No. 33, February 16, 2001, pp. 10695-10697.
14. Current Population Survey, “March Supplement 2001.” Prepared by Texas Department of Health, Office of Health Information Analysis.
15. Ibid.

Demographic Trends

The population of Texas is projected to grow in size and to change composition due to several identified factors. The first factor is projected growth in the total population of the state. The second factor is the projected larger-than-average growth in the size of the non-Anglo population and in the size of the population age 65 or older. According to the 2000 U.S. Census, Texas had the second largest population of all states (behind California) with approximately 20.0 million (20,851,820) residents. Approximately 11.1 million Texans were Anglo, approximately 6.7 million Texans were Hispanic, and approximately 2.4 million Texans were African American. Other racial/ethnic groups comprised the remaining approximate 700,000 Texans.¹ Of the 6.7 million Hispanics in Texas in 2000, more than five million (76 percent) were of Mexican origin.²

The population of the state has risen noticeably in the last decade (see Figure 3.4). Between 1990 and 2000, Texas' population grew by almost 4 million, from about 17 million to almost 21 million. Between 2002 and 2007, the state's population is expected to increase by about 1.7 million or 8 percent. Robust growth is also expected over the long-term. Between 2000 and 2010 the rate of total population growth could reach 16 percent while between 2000 and 2040 the growth rate could exceed 100 percent, with the population essentially doubling in size.³

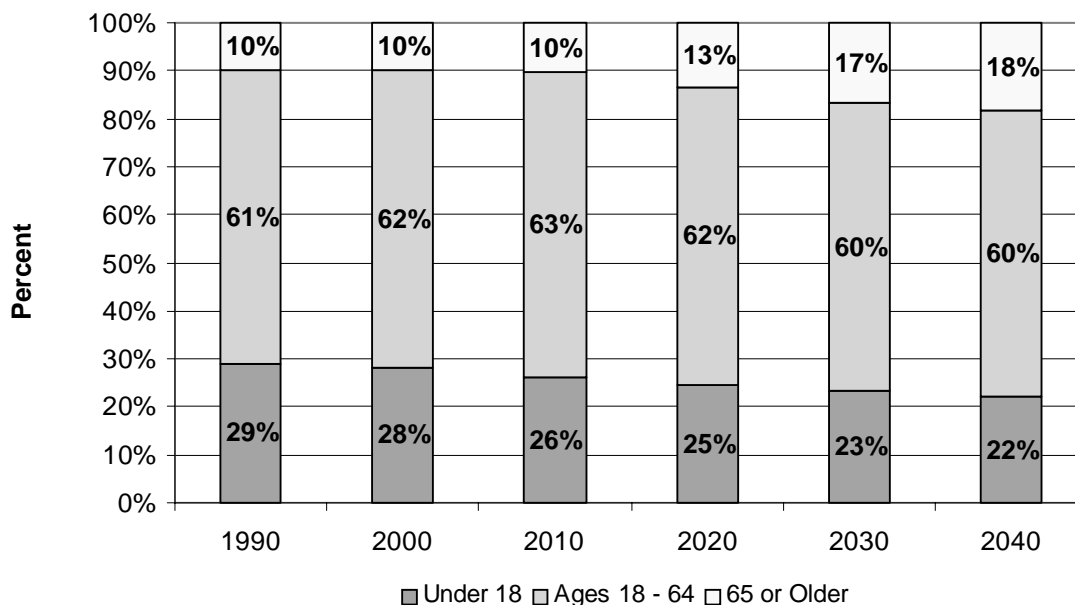
Figure 3.4 Percent Growth in Texas Population: Selected Periods



Data Source: Texas State Data Center. Data for 2002 - 2040 period are based on migration growth scenario 0.5 projections. December 2001.

More specifically, all major age cohorts (children under 18, adults ages 18 – 64, and adults age 65 or older) are expected to expand in size over the short-term (see Figure 3.5). Between 2000 and 2010, the population of children under 18 is projected to increase by 400,000; the adult population ages 18 – 64 is expected to increase by about 2,400,000; and the adult population age 65 or older is expected to increase by about 400,000. Over the long-term, children under 18 are projected to account for a shrinking share of the state's population; their share is expected to decrease from 28 percent in 2000 to 26 percent in 2010, and then down to 22 percent in 2040. But persons age 65 or older are projected to account for a larger share of the state's population. Their share could increase from 10 percent in both 2000 and 2010 to about 18 percent in 2040. In the year 2011, the oldest members of the 'baby boom' generation will start turning 65.⁴

Figure 3.5 Percent Share of Texas' Total Population by Age Group: Selected Years

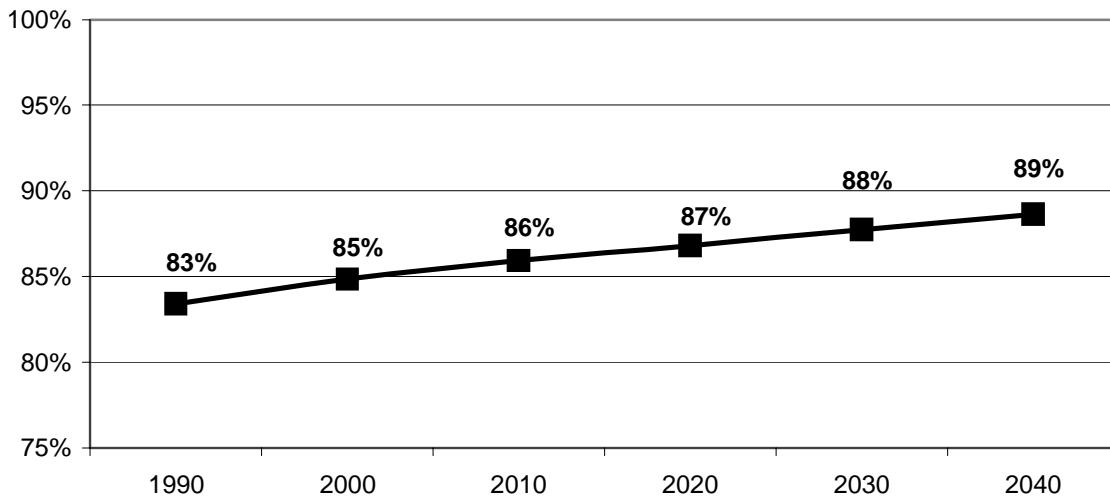


Data Source: Texas State Data Center. Data for 2010 - 2040 are based on migration growth scenario 0.5 projections. December 2001.

In terms of where the population resides, the percentage of Texans living in metropolitan areas is expected to remain high (see Figure 3.6). In 1990, approximately 83 percent of Texas' population lived in metropolitan areas. In 2010, approximately 86 percent of the population will live in the 58 counties currently designated as metropolitan. But the percent residing in metropolitan areas is projected to increase only slightly over the next four decades, from 85 percent in 2000 to about 89 percent in 2040.⁵ In 2002, about 60 percent of the state's population resides in three non-border regions that contain the largest metropolitan areas of the state: the Metroplex region, home to the Dallas-Forth Worth metro area, with 26.5 percent of the total; the Gulf Coast

region, home to the Houston-Galveston metro area, with 23.3 percent; and the Central Texas region, home to the Austin-San Marcos metro area, with 11.1 percent. The border regions (Lower South Texas, Upper Rio Grande, and Upper South Texas), which are home to the metro areas of Brownsville, Corpus Christi, El Paso, Laredo, McAllen, and San Antonio, account for about 22 percent of the state's population. Finally, the rural regions of the state account for less than 20 percent of the state's population in 2002.⁶

Figure 3.6 Percent Distribution of the Texas Population According to Metropolitan Residence: Selected Years

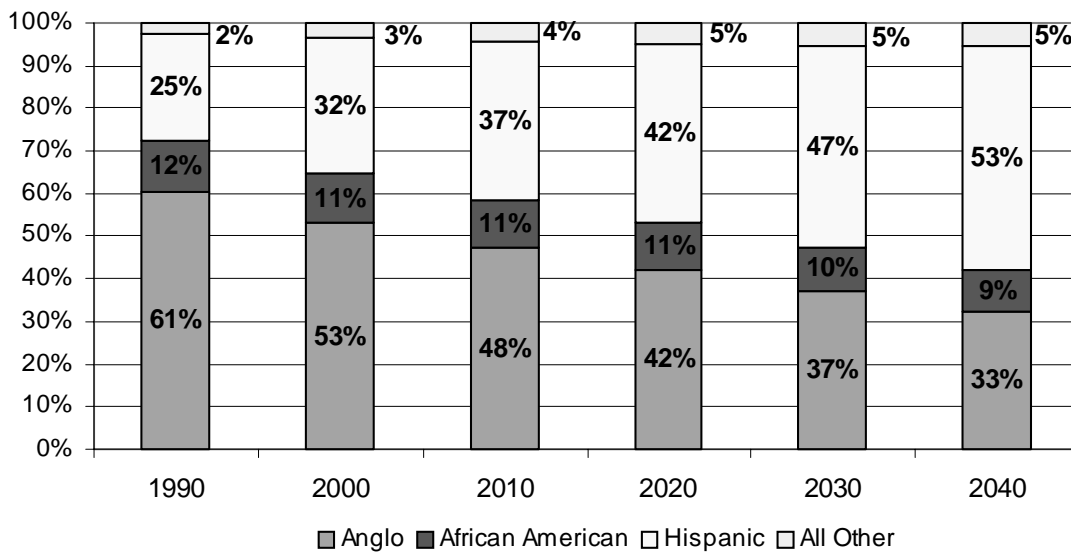


Data Source: Texas State Data Center. Data for 2010 - 2040 are based on migration growth scenario 0.5 projections. December 2001.

Demographics in terms of race and ethnicity demonstrate that in 2002, the largest relative concentrations of Hispanic residents are located near or along the Texas-Mexico border. In both the Lower South Texas and Upper Rio Grande regions Hispanics represent approximately 80 percent of the total population. The Lower South Texas region is expected to increase its share of the state's population in the future. African American residents are largely concentrated in Southeast Texas, Upper East Texas, and the Gulf Coast regions. In those regions, roughly about 1 out of every 5 residents is African American. In addition, regions with some of the largest relative concentrations of African Americans, like the Upper East Texas and Southeast Texas regions, also have some of the largest relative concentrations of Anglo residents. Those regions have a lower than average relative concentration of Hispanic residents. The Northwest Texas region has the largest relative concentration of Anglo residents in the state (76 percent).⁷

There are several projected changes in the current demographic picture (see Figure 3.7). First, it is projected that Anglos' relative share of the state's population will continue to decrease over the foreseeable future. Their share may decrease from 53 percent in 2000 to about 33 percent in 2040. Moreover, African Americans' relative share is projected to decrease also, from 11 percent in 2000 to about 9 percent in 2040. In contrast, Hispanic's relative share is projected to increase, from 32 percent in 2000 to 53 percent in 2040. The relative share of all other groups combined is projected to remain relatively low, but increasing from 3 percent in 2000 to about 5 percent in 2040.⁸

**Figure 3.7 Percent Share of Texas' Population
by Race / Ethnicity: Selected Years**



Data Source: Texas State Data Center. Data for 2010 - 2040 are based on migration growth scenario 0.5 projections. December 2001.

Endnotes:

1. Office of the State Demographer, Texas State Data Center
2. U.S. Census, 2000
3. Office of the State Demographer, Texas State Data Center
4. Ibid.
5. Texas State Data Center. Data for 2010-2040 are based on migration growth scenario 0.5 projections. December 2001.
6. Office of the State Demographer, Texas State Data Center
7. Ibid.
8. Ibid.

Texas Health Status Profile

Maternal and Child Health

The infant mortality rate (IMR) is the number of deaths to infants less than one year of age per 1,000 live births. IMR has historically served as an important indicator of the overall health of the community and is a composite indicator of the quality of, and access to, medical care for pregnant women and infants. Risk factors for increased infant mortality include congenital abnormalities, infectious, barriers to maternal healthcare, prematurity or low birthweight, mothers who fail to acquire prenatal care in the first trimester, mothers who are teens or women who smoke during pregnancy.¹ The leading cause of infant mortality is birth defects.²

The overall infant mortality rate in Texas in 2000 was 5.7 per 1,000 live births.³ The Texas infant mortality rate declined 20.0 percent between 1990-1999, from 8.0 deaths per 1,000 live births to 6.2 deaths per 1,000 live births.⁴ From 1989-1999, African American infants, on average, died at a rate twice that of all other infants born in Texas.⁵ The African American infant mortality rate in 2000 (11.4) followed historical trends and continued to be considerably greater than the rate of Anglos (4.8) and Hispanics (5.3).⁶

Neural tube defects (NTDs) are a group of birth defects caused by the failure of the neural tube to properly develop during the embryonic stage of development. The major types of NTDs are anencephaly and spina bifida. NTDs are associated with inadequate folic acid consumption by mothers prior to conception. Genetics, maternal metabolic defects, diabetes, and maternal obesity may also contribute to NTDs.⁷

The 1995-1997 birth prevalence of anencephaly in Texas was 3.78 per 10,000 live births while the 1995-1997 birth prevalence of spina bifida was 5.29 per 10,000 live births.⁸ Provisional data from the Texas Birth Defects Registry indicate that spina bifida rates have been decreasing steadily to just under four cases per 10,000 live births in 1999.⁹ The fourteen counties bordering Mexico have consistently demonstrated exceptionally high rates of neural tube defects, with anencephaly rates spiking at times in certain counties to as high as 26 per 10,000 live births.¹⁰

Low birth weight is defined as an infant who weighs less than 2500 grams at birth. Low birth weight places infants at increased risk for negative health outcomes and even death. In 2000, there were 26,751 low birth weight infants born to Texas residents which was 7.4 percent of all live births in Texas.¹¹ A modest increase in the rate of low birth weight was evident during the 1990's; it rose from 7.0 percent in 1990 to 7.4 percent in 2000.¹² The percentage of low birth weight African American infants (12.7) was almost twice that of low birth weight Anglo infants (6.6) or Hispanic infants (6.8) in 2000.¹³

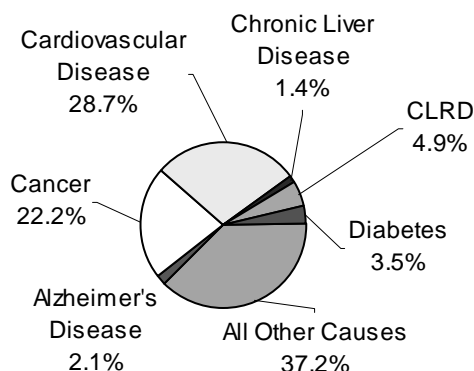
Causes of Death

A total of 149,763 Texas residents died in 2000. The leading cause of death, diseases of the heart, accounted for 28.7 percent of those deaths, while the second most common cause of death, malignant neoplasms (cancer), accounted for 22.2 percent. Cerebrovascular diseases, accidents, and chronic lower respiratory diseases (CLRD) ranked third, fourth, and fifth, respectively. Together, these five leading causes of death represented 68.0 percent of all deaths in 2000. The order of the top three leading causes of death has remained the same since 1979.¹⁴

Disease Trends: Chronic Disease

As noted above, four of the five leading causes of death in Texas in 2000 were chronic diseases: heart disease, cancer, stroke, and chronic lower respiratory disease. Other chronic diseases among the top ten leading causes of death in Texas were diabetes and chronic liver disease/cirrhosis.¹⁵ As illustrated by Figure 3.8 below, chronic diseases caused a clear majority of the deaths in Texas in 2000.

Figure 3.8 Texas Mortality Due to Chronic Diseases, 2000



Source: Texas Department of Health, Bureau of Vital Statistics, 2002.

Disease of the heart is a term that describes several disorders that reduce blood supply to the heart. Diseases of the heart are the leading cause of mortality in both men and women in Texas. Close to 43,000 deaths in Texas in 2000 were attributable to diseases of the heart.¹⁶

Diabetes is classified as either Type I or Type II. Type I diabetes most often appears in childhood or adolescence. Type I diabetics are unable to produce insulin and require insulin or other drug interventions. Type II diabetes' onset is usually not until older adulthood and it affects 90-95 percent of people with diabetes. It can often be controlled by maintaining a healthy diet, increasing physical activity, and reducing weight.¹⁷

A recent phenomenon reported in Texas is the increased incidence of Type II diabetes in children. While there are currently no data on the prevalence of Type II diabetes in children in Texas, there is anecdotal evidence that it is becoming a problem and research is ongoing. If increasing numbers of children do develop Type II diabetes, the complications related to diabetes such as cardiovascular disease, blindness, and amputations that are typically seen in the elderly could be seen in younger adults.¹⁸

In 2000 in Texas, diabetes was the sixth leading cause of death, causing 5,195 deaths.¹⁹ The number of deaths related to diabetes may be understated because death records often fail to reflect the role of diabetes.²⁰ Five-year average age-adjusted mortality data shows that mortality rates for African Americans and Hispanics were two to three times higher than for Anglos (56.1 per 100,000 for African Americans, 53.3 per 100,000 for Hispanics, and 22.4 per 100,000 for Anglos, using the 2000 standard population).²¹

Currently, more than two million Texans are age 65 and older—approximately 10 percent of the population.²² Many chronic diseases, such as diabetes and cancer, affect the elderly more often and/or more severely than other age groups. Osteoporosis, arthritis, and Alzheimer's Disease are three chronic diseases that predominantly affect the elderly, defined as persons who are 65 years and older.

Osteoporosis is a disease in which bones become weak and are more likely to break. The causes of osteoporosis are unknown, but many risk factors for osteoporosis have been identified, such as a thin and/or small frame, being postmenopausal or having had early menopause, low calcium intake; and physical inactivity.²³ If not prevented or if left untreated, osteoporosis can progress painlessly, without symptoms, until a bone breaks.

Approximately 2 million Texans have osteoporosis or low bone mass and 80,000 Texans experience osteoporosis-related fractures each year.²⁴ Currently, almost three-fourths of osteoporosis costs occur in older Texans.²⁵ In 2015, an estimated 2.85 million women and 418,000 men will have both osteoporosis and low bone mass.²⁶

Arthritis is a term used to describe more than 100 conditions that affect joints and connective tissues, including rheumatoid arthritis, osteoarthritis, gout, and fibromyalgia.²⁷ While arthritis usually does not cause death, it is a leading cause of disability and suffering in Texas. Arthritis often begins soon after age 40 from years of wear on joints. People who are more than 10 pounds overweight have a higher risk for arthritis especially in weight-bearing joints like the knees.²⁸ In 1999, 1.5 million Texans reported arthritic conditions as a cause of activity limitation.²⁹ An estimated 1.8 million women in Texas reported arthritis in 1999 compared to 1.1 million men.³⁰

Alzheimer's disease is a progressive degeneration of the brain that causes a steady decline in memory, thinking and behavior, which becomes severe enough to interfere with everyday life. How rapidly the disease progresses varies from person to person, but all sufferers experience confusion, personality changes and impaired judgment. Alzheimer's Disease is a terminal illness. Although there are medications that may alleviate some of the symptoms, there is at present no prevention or cure for the disease.³¹

In Texas 280,000 people have Alzheimer's Disease or a related disorder.³² In 2000, Alzheimer's was the eighth leading cause of death in Texas accounting for 3171 deaths or 2.1 percent of deaths.³³ One in 10 Texans over 65, and nearly half of those over 85, have Alzheimer's Disease.³⁴

Disease Trends: Infectious Diseases

Texas had 2,981 AIDS cases (rate of 14.4 per 100,000 population) and 4,241 HIV cases (rate of 20.5 per 100,000 population) reported in 2001. At the end of 2001, 68,327 Texans had been diagnosed with HIV or AIDS, 36,309 of which were still living. New HIV cases in 2001 occurred more frequently in both the 30 to 39 age group (50.3 per 100,000) and the 20 to 29 age group (41.4 per 100,000).

The rate of reported HIV cases in 2001 among African Americans (77.0 per 100,000) was more than five times higher than the rate for Anglos (13.1 per 100,000) or Hispanics (14.0 per 100,000). The 2001 AIDS rate among African Americans (49.2 per 100,000) was more than five times higher than the rate for Anglos (8.7 per 100,000) and nearly four times higher than the rate for Hispanics (12.6 per 100,000). The AIDS rate for Texas males in 2001 was 22.8 cases per 100,000 and the HIV rate was 30.1 per 100,000. The female AIDS rate was 6.2 cases per 100,000 and the HIV rate was 11.1 per 100,000. Because HIV cases represent more recent infections than AIDS cases, the higher rates among females with HIV compared to those with AIDS is an indicator of the increasing spread of new infections among females.³⁵

Hepatitis A is one of the most commonly reported infectious diseases in Texas. In 1999 there were 2,516 cases of Hepatitis A reported from 154 Texas counties with four deaths. Children ages five to nine typically have the highest rates of Hepatitis A (29.5 per 100,000 in 1999). In 1999, Hispanics had the highest incidence of Hepatitis A at 19.6 per 100,000 (Anglos were 5 per 100,000 and African Americans were 2 per 100,000).³⁶

Two vaccines are currently in use to prevent Hepatitis A infection. The vaccines are available in a 2-dose series and can be used in persons over the age of two years. In August 1999, a law was passed requiring all child-care facility attendees and school aged children who live in the 32 Texas counties within 100 kilometers of the Texas-Mexico border to be vaccinated against Hepatitis A by August 2000.³⁷

Hepatitis B (HBV) is known to cause acute and chronic hepatitis. Perinatal transmission occurs when an infant is exposed to infectious maternal blood during birth. However, immunotherapy provided to infants of HBV-infected mothers will prevent 97 percent of subsequent infections. A total of 864 cases of HBV were reported in Texas in 1999 from 88 counties with three deaths. Among ethnic/racial groups, African Americans had the highest incidence rate at 3.5 per 100,000.³⁸

Hepatitis C virus (HCV) is the most common blood borne pathogen in the US.³⁹ It is also the leading cause of chronic liver disease in the United States.⁴⁰ The actual number of individuals infected with Hepatitis C in Texas is unknown. Only acute Hepatitis C is reportable. In 1999, 359 cases of acute Hepatitis C were reported to TDH. The statewide rate for acute Hepatitis C in 1999 was 1.8 cases per 100,000 population. Hispanics had the highest rate of acute Hepatitis C (1.7 per 100,000); Anglos had a rate of 1.1 and African Americans had a rate of 1.0. However, data on race/ethnicity are incomplete; many records fail to record these data or record them as unknown.⁴¹

In 2000, 1,506 cases of tuberculosis (TB) were reported in Texas, which is 59 percent lower than the 2,542 cases of TB reported in 1994.⁴² High TB rates in the Mexican states that border Texas contribute to a higher rate for TB in the Texas counties near the Mexican border as compared to the rest of the state. The 14 Texas counties that border Mexico had a TB rate of 12.6 cases per 100,000, which is 1.7 times the rate of the Texas TB rate of 7.4.⁴³

In 2000, Texas had 58 reported cases of TB that were resistant to one of the most common drugs for TB (Isoniazid). Seven of those cases were resistant to both Isoniazid and Rifampin.⁴⁴ If drug resistant TB is allowed to develop, the cost of treating a case can escalate from \$2,300 to over \$250,000 per case.⁴⁵

Health Risks

In Figure 3.9 on the next page, the seven leading causes of mortality in Texas in 2000 are listed across the top and behavioral risk factors that contributed to these causes of death are listed down the side. As indicated by the figure, two major behavioral risk factors that contributed to the leading causes of death are cigarette smoking and issues related to a sedentary lifestyle: physical inactivity; poor nutrition; and being overweight or obese.

In 2000, 22 percent of Texans smoked. Smoking among youths is particularly problematic. In 2000, 59,900 Texan youths under the age of 18 became new daily smokers, while 28 percent of Texan high school students reported smoking.⁴⁶ In 1999, 370,685 Texan youths were projected to die prematurely as a result of their tobacco use. In general, tobacco use is responsible for more deaths in Texas each year than alcohol, auto accidents, AIDS, drugs, homicides, suicides, and fires combined.⁴⁷ Unfortunately, the prevalence of smoking

among Texas adults remained virtually unchanged between 1990 and 2000.⁴⁸ Prevention of smoking not only improves health and offers an extended lifespan but it also saves tax dollars. For example, for fiscal year 2001, Texas spent \$0.59 per capita (or \$12,362,828 total) of combined federal and state funds on tobacco control. In contrast, in fiscal year 1993, Texas spent \$654,003,000 on smoking related Medicaid expenditures.⁴⁹

Figure 3.9 Risk Factors for Specified Diseases

	Diseases of Heart	Cancer	Cerebro-vascular Diseases	Accidents	Chronic Lower Respiratory Disease	Diabetes	Influenza/Pneumonia
Cigarette Smoking	+	+	+		+		
Physical Inactivity	+	+	+			+	
Poor Nutrition	+	+	+			+	
Overweight/Obesity	+	+	+			+	
Alcohol Use	+	+	+	+			
No Pneumonia Immunization for 65+							+
Not Utilizing Screenings	+	+	+				

Source: Texas Vital Statistics, 2000, created by Office of Health Information and Analysis, Texas Department of Health

Being overweight dramatically increases one's risk for high blood pressure, high cholesterol, Type II diabetes, heart disease, and stroke. Accumulating evidence suggests that obesity increases the risk of certain cancers (endometrium, breast, uterine, ovarian, gallbladder, prostate, and colon cancer.)⁵⁰

In 2000, 36.7 percent of Texas adults were overweight. The general trend between 1990 and 2000 was an increasing percentage of adults to be overweight. In 1990, 30.6 percent of Texas adults were overweight. On average, men are overweight at a rate higher than women. In 2000, 45.4 percent of men were overweight and 28 percent of women. African Americans had the highest reported percentage (40.2 percent) of overweight for the three major ethnic groups in 2000. Anglos averaged 37.5 percent and Hispanics averaged 35.2 percent.⁵¹

Across the nation, 300,000 premature deaths each year in the U.S. are caused by obesity. In 1995 the total cost from overweight/obesity in the United States was estimated at \$99.2 billion; direct costs were \$51.6 billion or 5.7 percent of the United States' health expenditures while indirect costs from overweight/obesity were \$47.6 billion.⁵²

Texas is the first state in the nation to examine the prevalence of obesity among school-aged children at the state level. Results indicate that the prevalence of overweight (Body Mass Index \geq 95 percentile for age and

sex) among children in Texas is far worse than the prevalence of overweight among children in the nation as a whole. Among school-aged children in Texas in 2001:⁵³

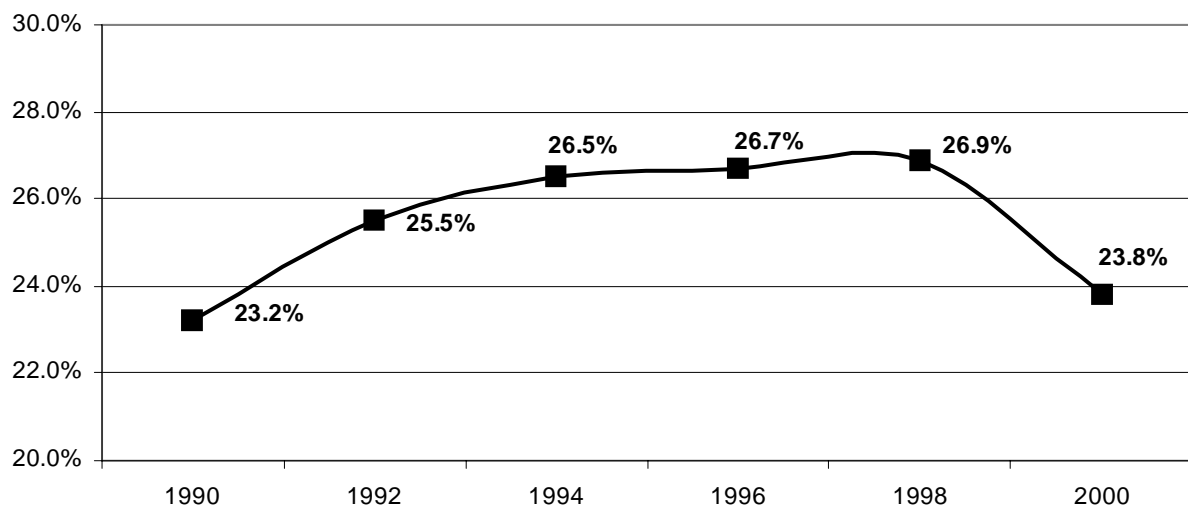
- 4th grade – 21 percent of the girls and 24 percent of the boys were overweight.
- 8th grade – 17 percent of the girls and 21 percent of the boys were overweight.
- 11th grade – 12 percent of the girls and 19 percent of the boys were overweight.

Regular physical activity decreases the risk of coronary heart disease and overall mortality. People who are sedentary have twice the risk for heart disease than those who are active.⁵⁴ In addition to the potential for reducing mortality, physical activity has shown to be beneficial for control of hypertension, diabetes, and weight, and in reducing osteoporosis, anxiety, and depression.⁵⁵ In 2000, approximately 28.5 percent of respondents in Texas indicated no physical activity during the past month.⁵⁶

Texas Health Insurance Coverage Rates

In recent years, Texas has demonstrated high rates of uninsurance. For example, in 2000, 21.4 percent of all Texans had no health insurance compared with 14 percent in the United States.⁵⁷ There have been minor year-to-year fluctuations in the rate over the last 10 to 12 years. Even during time periods characterized by vigorous economic conditions, such as the late 1990's, the rate of uninsurance remained above 20 percent. This may be due to the increasing population of the state; over the ten-year period from 1989 to 1999 the percentage of uninsured in Texas remained relatively constant but the number of Texans lacking health insurance grew from three to four million.⁵⁸

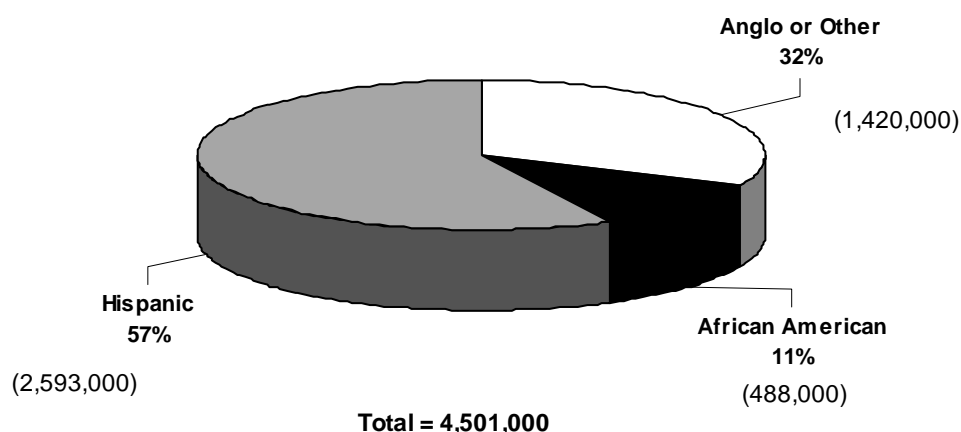
**Figure 3.10 Percent of Texans (Under Age 65)
Without Health Insurance: Selected Years**



Data Source: U.S. Census Bureau. March 2001 Current Population Survey (CPS)
for selected historical periods.

In 2000, the rate of uninsurance for persons under age 65 was approximately 24 percent, representing 4.4 million individuals in the state (see Figure 3.10). Among persons age 65 or older, the rate of uninsurance is almost zero, due to medical coverage under the Medicare program.⁵⁹ More than 22 percent (22.5) of males and 20.3 percent of females lacked health insurance in 2000.⁶⁰ By race/ethnicity, the data shows that in 2000, 12.2 percent of Anglos lacked health insurance, while 21.2 percent of African Americans and 36.7 percent of Hispanics also did not have health insurance (see Figure 3.11).⁶¹ Overall, Hispanics make up 57.6 percent of the uninsured population.⁶²

Figure 3.11 Uninsured Texans in Year 2000 by Race / Ethnicity



Data Source: U.S. Census Bureau. March Current Population Survey (CPS) for Texas.

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Impact of State and Federal Legislation

Like most government agencies, Texas Department of Health (TDH) expends a considerable amount of effort addressing a number of issues that develop through state and federal legislation. Texans can reap the rewards of higher quality public health services if the department can successfully address and manage the legislative issues that are brought forth in successive legislative sessions.

Medicaid Reform

The 77th Texas Legislature demonstrated its concern with the Medicaid program by passing Senate Bill 1156, which contained within its provisions the transfer of most Medicaid programs from TDH to the Health and Human Services Commission (HHSC). Despite Governor Perry's veto of the bill, sufficient consensus existed among legislative policymakers to implement the transfer of the Medicaid program without a statute change.

Effective September 1, 2001, HHSC assumed all policy, budget and management responsibility for most of the state's Medicaid Program. TDH retained authority over the Medicaid programs that are more closely aligned with the public health mission of the agency. Notable among the programs remaining at TDH are the Texas Health Steps (medical and dental) and the Medical Transportation program.

The removal of responsibility for managing major portions of the Medicaid program will allow TDH to revisit management priorities and restate the vision and mission of the agency. A refocused TDH has the ability to emerge as a more efficient and effective public health leader.

Immunizations

The importance of maintaining high levels of immunization cannot be overstated as a public health objective. State leaders have expressed concern that Texas immunization rates for preschool-aged children are lower than the national average. Higher immunization rates will serve the dual purpose of protecting those that are immunized from disease as well as protecting those who for various reasons cannot be vaccinated. The Commissioner of Health has directed that TDH's Bureau of Immunization and Pharmacy Support increase immunization levels for two-year olds to 90 percent by December 31, 2005.

In an appropriations rider to Senate Bill 1 during the 77th Texas Legislature, TDH was directed to submit a report each September 30 of the biennium (2001-2002) to the Legislative Budget Board and the Governor on plans to increase immunization rates in Texas, with the primary focus to be placed upon pre-school age children. Legislative intent is that TDH use the report to manage available resources for increasing immunization rates. The following elements must be included in the report:

- Methodology used to determine immunization rates;
- Immunization rates broken down by geographic region so that appropriate focus can be directed to areas with rates lower than the state average;
- Specific information detailing changes to agency procedures, contracted services, performance measures and estimated costs needed to increase immunization rates; and
- Estimates of the impact each method proposed, individually and collectively, toward achieving an increase in immunization rates.

The first required report contains several proposed strategies for achieving the legislature's goal. Community involvement, provider and parental awareness and participation, improvement of data systems (such as ImmTrac), and bringing elements of TDH operations that touch on immunizations together to formulate a uniform strategy are all methods that TDH proposes to utilize in order to achieve the commissioner's and the legislature's objectives.

TDH Hospitals

Management of the Texas Center for Infectious Disease (TCID) and the South Texas Health Care System (STHC) has been the responsibility of TDH since 1954. Primarily established to provide tuberculosis (TB) related services, these institutions are also authorized to care for individuals afflicted with other infectious and/or chronic respiratory diseases.

An appropriations rider to Senate Bill 1 of the 77th Legislature provides funding to replace the TCID facility in San Antonio and construct new outpatient treatment centers for the South Texas Health Care System in Cameron and Hidalgo counties. The general obligation bonds to finance the projects were part of a larger bond initiative approved by Texas voters in November 2001. Currently, it is estimated that these two projects will cost \$34 million.

This project is the continuation of a long-range plan begun at the behest of the 75th Legislature. The need to control the spread of TB and treat TB-infected patients and the danger of these aging facilities losing accreditation and federal funding provided the impetus to put forth a long-range plan to improve these institutions that serve a critical need in their local communities.

Cancer Incidence Reporting

The collection of meaningful data is an important tool used by health agencies when battling chronic diseases. Senate Bill 285 passed by the 77th Legislature enhanced TDH's collection of cancer incidence data by adding health practitioners to the list of entities required to report cancer data to the Cancer Registry. The Cancer

Registry gathers and publishes data on cancer incidence and mortality rates in Texas. Adding this provision establishes that the Texas Cancer Registry meets all federal statutory requirements of the Centers for Disease Control (CDC) for continued federal funding under the National Program of Cancer Registries.

Health Disparities

In 1993, the 73rd Texas Legislature mandated TDH to address minority health and cultural competency. The goal was to promote and coordinate initiatives designed to improve the health of all minority and disadvantaged populations in Texas. The increasingly diverse racial/ethnic population in Texas, the existence of an international border, and the insurance status of Texas residents present a complex set of difficulties when dealing with this issue.

In an attempt to address growing concerns about health disparities, the 77th Legislature passed House Bill 757 that established the Health Disparities Task Force. The task force is charged with the responsibility to consult with the TDH in eliminating health and health access disparities in Texas among multicultural, disadvantaged, and regional populations. The establishment of the task force makes the state of Texas one of the first states in the country to legislatively mandate a task force to look into the differences in the health of various groups. The task force is also required to submit an annual report to the Governor, Lieutenant Governor, and Speaker of the House of Representatives on TDH's progress in accomplishing these goals.

Childhood Asthma Disease Management Study

Asthma is the most common chronic disease among children and the leading cause of school absences among youngsters under 16. Children with asthma miss twice as many school days as do children who do not have asthma. In an attempt to find the most effective treatments for children's asthma, the 77th Legislature passed House Bill 342 that establishes a children's asthma disease management pilot study. Both urban and rural areas must participate in the study in which participants must utilize techniques that are transferable to private practice. The study must compare preventative disease management methods for treatment of children's asthma with traditional methods for treating the disease. House Bill 342 requires TDH to submit an interim report to the legislature containing the pilot study's findings no later than November 1, 2002.

Pediatric Diabetes Research Advisory Committee

In Texas, approximately two million people have diabetes, and at least one million are undiagnosed. In response to these numbers and the potential future costs for treatment of individuals with diabetes, the 77th Legislature passed Senate Bill 1456 to create the Pediatric Diabetes Research Advisory Committee. The bill requires that TDH establish the advisory committee in consultation with the Texas Diabetes Council. The advisory committee is directed to conduct analyses and assessments for the purpose of providing advice to the legislature and

governor on the development of a plan to investigate scientific research opportunities for pediatric diabetes in Texas. In addition, the advisory committee will assess resources, talent, and the economic and health related burdens resulting from diabetes.

The advisory committee must submit its report to the governor, lieutenant governor, and speaker of the house no later than December 1, 2002. The legislation further requires that the advisory committee will be abolished January 1, 2003.

Bioterrorism

The events surrounding the terrorist attacks of September 11, 2001 served as a catalyst for Texas and the entire nation to increase their awareness and knowledge of the threat of terrorism. In keeping with the idea that education is a key component to fighting terrorism, TDH is utilizing substantial resources of its own as well as federal funds to address bioterrorism from a public health perspective. TDH is developing a Bioterrorism Preparedness and Response Plan designed to provide operational guidelines for bioterrorism preparedness and response.

TDH will receive \$8.3 million from the federal Health Resources and Services Administration (HRSA) to upgrade the preparedness of hospitals and health care systems to respond to bioterrorist events as well as outbreaks of infectious and rare diseases. The federal grant requires TDH to conduct an assessment of hospital bioterrorism preparedness before awarding funds to hospitals and to convene a Hospital Bioterrorism Preparedness Planning Committee to make recommendations on the priorities and process to provide funding to hospitals.

TDH will receive \$51.4 million in federal funding through the Centers for Disease Control and Prevention (CDC) for bioterrorism preparedness and response. The CDC serves as the federal agency that must approve each state's bioterrorism work plan. Each state's work plan must be submitted to the state governor for approval and direct transmission with a letter of endorsement to the Secretary of Health and Human Services. Each state work plan must address the following topics:

- Preparedness Planning and Readiness Assessment;
- Surveillance and Epidemiology Capacity;
- Laboratory Capacity - Biologic Agents;
- Health Alert Network/Communications and Information Technology;
- Risk Communication and Health Information Dissemination (Public Information and Communication);
- and
- Education and Training.

Due to increased scrutiny of this issue at both the state and federal levels, bioterrorism preparedness and response will be an ongoing concern for public officials, thus making TDH's efforts critical to the agency's mission to protect public health.

Internal Assessment

The Texas Department of Health (TDH) internal assessment is an evaluation of TDH's core administrative structure. The assessment is not an exhaustive evaluation of all the core functions of every TDH program because such an assessment would be cost prohibitive. Nonetheless, the assessment touches on essential areas including fiscal, capital, information technology, workforce diversity and training, employee satisfaction, and minority contracting. All of these areas affect nearly every program and enable TDH programs to pursue the implementation of agency goals, objectives and strategies.

Fiscal Aspects

General revenue, Tobacco Settlement funds, Tobacco Endowment funds, special funds and fees collected from regulatory programs provide state funding for the Texas Department of Health (TDH). Federal funds, making up 52 percent of the budget, come from a wide variety of federal block grants and discretionary programs, with Medicaid funds representing \$215 million of the annual \$786 million total federal funds. Funding is distributed over six goals outlined below (see Table 3.4).

Table 3.4 Funding for TDH Goals

Goal	State Funds	Other Funds	Federal Funds	Total 2002 Budgeted
A. Prevention and Promotion	345,343,629	9,005,027	474,649,242	828,997,798
B. Medicaid Services	129,923,149	212,203	189,493,485	319,628,837
C. Health Care Standards	22,216,929	5,512,903	6,848,998	34,578,830
D. Equitable Access	74,182,503	2,366,359	96,690,755	173,239,617
E. Coordinated Health System	78,946,240	36,050,090	3,617,492	118,613,822
F. Indirect Administration	21,019,140	2,285,467	15,459,555	38,764,162
Total Budgeted	671,631,490	55,432,049	786,759,527	1,513,823,066

Source: Texas Department of Health FY 2002 Operating Budget, November 1, 2001

The annual TDH budget for fiscal year 2002 is \$1.5 billion. The budget is comprised of \$786 million in federal funds and \$672 million in state funds of which \$131 million is state match for Medicaid. The budget also includes other funds such as interagency contracts, appropriated receipts, and general obligation bond proceeds.

Capital Improvement Needs

In response to the long-range plan for the TDH hospitals submitted to the 77th legislature, \$33.9 million of General Obligation Bonds were appropriated to TDH to be used in hospital construction and renovation. As part of the long-range plan for the South Texas Hospital and the provision of tuberculosis treatment and other health care services in the Lower Rio Grande Valley, \$16.6 million (of the \$33.9 million) is planned for use in constructing physical facilities for outpatient health care services in Hidalgo County (\$8.3 million) and in Cameron County (\$8.3 million). As part of the long-range plan for the Texas Center for Infectious Disease and the provision of tuberculosis and communicable infectious disease health care and laboratory services, \$17.3 million (of the \$33.9 million) is planned for the renovation of existing physical facilities and/or construction of new physical facilities.

Construction of the new TDH laboratory in Austin continues to be a priority for the FY 2002-2003 biennium. The parking garage has been completed and is currently in use. Construction on the laboratory/office building is substantially complete and the building is expected to be occupied in June, 2002. The building is funded through revenue bonds that will be repaid primarily through laboratory-generated fees.

As with all parts of this assessment, this section is not an exhaustive evaluation of all of the capital needs of each program. For more information on TDH capital needs, please review the *Biennial Operating Plan and Information Technology Strategic Plan*.

Information Resource Management

Texas legislation defines information resources (IR) as the procedures, equipment, and software that are employed, designed, built, operated, and maintained to collect, record, process, store, retrieve, display and transmit information, and associated personnel including consultants and contractors. IR technologies are defined as data processing and telecommunications hardware, software, services, supplies, personnel, facility resources, maintenance, and training. Information resources management therefore implies the management of these information resources and IR technologies (see Appendix E).

Information resources at the Texas Department of Health (TDH) have historically been decentralized due to the wide range of health services offered across a diverse geographic territory with funding from multiple sources. In a traditional bureaucracy-centered approach to delivering services, local control of IR provided the most responsive solutions for delivering services to the citizens of Texas.

The current expectation for government agencies is to provide information more efficiently. Providing online citizen-centered services instead of traditional approaches is the e-government solution. With ever-increasing computer capacity and bandwidth available at reduced cost, the ability to deliver cost-effective solutions rests with agency-wide IR management planning at the agency and the enterprise level.

Key achievements

Recent Health and Human Services enterprise-wide initiatives implemented at TDH are:

- Microsoft Exchange/Outlook e-mail and calendaring
- Microsoft Office desktop productivity suite
- PeopleSoft Financials administrative systems
- Oracle Software database license
- Health & Human Services Commission Network (HHSCN)

An internal reorganization of the Information Systems Associateship created specific groups for enterprise or agency-wide projects, planning, standards, quality assurance, and security functions. The formation of an executive level IR Steering Committee (IRSC) provides high-level enterprise and agency-wide planning while regular communication with distributed IR staff helps to establish consistent goals and objectives. Standards oversight is now applied to all IR procurements.

The Health Insurance Portability and Accountability Act (HIPAA) analysis performed has created elaborate maps of the data flow between applications across the agency and outside. An assessment done for the

National Electronic Disease Surveillance System (NEDSS) Alert details database information in every program area and proposes to create an integrated data repository.

On-going processes

Activity related to TDH's bioterrorism response capability has been heightened in recent months. Expansion of the Health Alert Network (HAN) and funding for phase two of the NEDSS is expected. These projects extend the reach and depth of communication between various program areas within TDH and our external partners in health.

In conjunction with these initiatives, the overall agency network architecture is moving towards simplification, such as reducing the number of routers and switches while increasing the bandwidth of the primary links. As this infrastructure improves, servers can be consolidated for greater efficiencies and redundancy.

The Internet and Intranet development team is defining a common navigation structure for improved customer interaction. A consistent format for publishing information and enhanced tools will allow additional information to be published more readily.

Current projects supporting e-government

These projects are positioning the agency for improved e-government abilities.

- Health Alert Network (HAN)
- National Electronic Disease Surveillance System (NEDSS)
- Health Insurance Portability and Accountability Act (HIPAA)
- PeopleSoft Human Resources, version 8 web-enabled
- Tejas medical transportation system
- Professional Licensing web-enabled
- e-Grants

Future standards and procedures

These standards and procedures will move the agency toward improved e-government abilities.

- Review projects for e-government appropriateness
- e-Authentication security
- Agency-wide data dictionary and create an integrated data repository
- Adopt uniform data standards for patient medical record information (HL 7 ver 3)

Benefits of the network re-architecture

Simpler network architecture provides greater bandwidth and an ability to cluster servers in one or two data centers with additional benefits:

- Data center providing improved security, redundancy and cost-effectiveness;
- Network-attached storage (NAS) or more sophisticated storage area network (SAN);
- Video conferencing; and
- Voice over IP telecommunications (VoIP)

E-Government

Future trends

The general direction of business is toward electronic transactions and information flow. Nowhere is this intent more evident than with the federal government. The federal Office of Management and Budget has published its *E-Government Strategy* in which twenty-four projects are outlined. Several of these projects will directly impact Texas Department of Health (TDH). E-government manages and provides government services using the Internet.

- e-Grants project (Department of Health and Human Services) will streamline and simplify grant applications and provide a single portal for applying for any federal grant.
- Online eligibility project (Department of Labor) will help potential recipients identify government programs for which individuals may be eligible.
- Consolidated Health Informatics initiative (Department of Health and Human Services) will provide the basis for a simplified and unified system for sharing and reusing medical record information. Information will be shared among government agencies, their private healthcare providers and insurers through a single mechanism.
- e-Authentication initiative (General Services Administration) will build and enable the mutual trust needed to support wide spread use of electronic interactions between the public and government and across governments by providing a method for satisfactorily establishing ‘identity.’

Economic conditions

The impact of adverse economic conditions will, in fact, encourage migration of transactions and information flow to the Internet. The immediate use of electronic reporting and applications options instead of submission of hardcopy reports can reduce time, materials and handling costs. Implementation of online application forms for government assistance programs could further reduce time and materials costs. E-government offers opportunities to use existing and under-development networks and systems for multiple purposes, which will reduce the costs of duplication.

Education and marketing

TDH will mount an education initiative to inform staff of the concepts of “E” and how they can be applied to public health. This will include world-class public and private benchmarks, internal readiness assessment tools, and extended value stream management concepts. The initiative will also provide an understanding of the role of technology (systems and telecommunications) architecture, standards and stakeholders in successful “E” implementations.

Leadership group

Under the direction of the Information Resources Steering Committee (IRSC), TDH will establish the e-Government Leadership Group (E-Group) to develop goals and strategies, consider and prioritize projects and make recommendations to executive management concerning e-government. The E-Group will be led by IS. Because of the pervasiveness of e-government, every process at TDH could potentially be impacted by the work of this group.

The first task of the E-Group will be the adoption of a charter, followed closely by an internal assessment of TDH’s readiness for e-government. Based on that assessment and a fit gap analysis, strategies will be developed to address the technology architecture, standards and processes necessary to support broad e-government. A list of in-progress and potential e-government projects will be developed and prioritized. Current projects dealing with e-government include the following (based on the definition of e-government adopted by the 77th Legislature): National Electronic Disease Surveillance System (NEDSS), Health Level 7 (HL7), Health Insurance Portability and Accountability Act (HIPAA), e-Grants (project led by Governor’s Office of Budget and Planning), professional licensing, Health Alert Network (HAN), PeopleSoft/Human Resources Version 8, Tejas, and Data Management.

Historically Underutilized Business Goal

The Texas Department of Health (TDH) is required to use historically underutilized businesses (HUB) in purchasing and public work contracts, pursuant to the Government Code, Section 2161.123. TDH has established a specific goal to increase participation of HUBs:

We will establish and carry out policies governing delegated purchases, professional services, and public works contracting which foster meaningful and substantive inclusion of historically underutilized businesses.

The agency's objective is to promote full and equal business opportunities for all businesses and to make a good-faith effort to assist HUBs in receiving a portion of the total contract value of all contracts that TDH expects to award in a fiscal year. Another agency objective is to meet or exceed the percentage HUB participation goals of 25.1 percent building construction, 47 percent special trade construction, 18.1 percent professional services, 33 percent other services and 11.5 percent commodities. These participation goals were set by the Texas Building and Procurement Commission (TBPC) and based on the 1994 Disparity Study.

The Board of Health and TDH executives and senior management are committed to ensuring HUBs are given an opportunity to contract with TDH, and the agency is optimistic about its future efforts to meet or exceed TBPC HUB goals. Activities will be focused on:

1. Continuing to increase awareness and support among TDH programs and senior management; and
2. Outreach to potential HUB vendors and non-HUB contractors.

This will include assisting HUB vendors to become certified with TBPC, become familiar with TDH's purchasing procedures and opportunities, and providing other technical support, plus providing information and support to non-HUB contractors in their efforts to subcontract with HUBs.

Some of the major activities that TDH will undertake include:

- Aiding associateships and programs within our agency to create individual work plans for HUB usage, including program contact information, based on planned delegated purchases;
- Increasing agency outreach and participation in community groups and civic organizations;
- Ensuring that prime contractors make a good-faith effort (GFE) to subcontract with HUBs to the extent possible, by attending pre-bid conferences to explain and promote the GFE Program to potential contractors and providing them with technical assistance in locating HUBs;
- Regular e-mail notifications to HUBs of available agency bid opportunities;

- Scheduling on-site, face-to-face meetings between HUBs and decision makers from each associateship within the agency.

In addition to these efforts, TDH will continue those activities that have benefited the program in the past. These include:

- Assisting HUBs to become more competitive by co-sponsoring forums on business-related issues for HUB vendors;
- Participating in TBPC sponsored HUB Economic Forums;
- Continuing to perform as an agency liaison to TBPC and other governmental offices concerning HUB issues;
- Providing quarterly presentations to the Board of Health on HUB related activities;
- Collecting and maintaining bid data as it relates to HUB vendors;
- Continuing to track, promote and share information regarding TDH's HUB participation through the procurement card program with TDH program purchasers and managers; and
- Providing reports to various associateships and programs regarding their HUB participation percentages.

Texas Department of Health Workforce Profile

The Texas Department of Health (TDH) Workforce Plan is developed as required by Section 2056.002 of the Government Code. Appendix D provides the plan, which contains an in-depth analysis of the agency's workforce and recommendations. It addresses the current supply of human resources in terms of skills, classification titles, diversity and retirement eligibility of the workforce. The plan also addresses external and internal trends that might have an impact on the agency's ability to recruit and retain qualified resources. An analysis of shortages in the number of workers required in specific classifications and skills is also included. Finally, the plan provides strategies such as training and development, recruitment, and succession planning to address gaps in human resource requirements for various classifications and skills throughout the agency.

The main office of the Texas Department of Health is located in Austin, Texas with five additional sites located throughout the city. TDH is organized into eleven regions as mandated for health and human services agencies. Public Health Regions (PHR) 2 and 3, 4 and 5 North, 6 and 5 South, and 9 and 10 are administratively combined, and as a result, there are eight regional directors covering eleven regions. The eight regional offices are located in Lubbock (PHR 1), Arlington (PHR 2/3), Tyler (PHR 4/5 North), Houston (PHR 6/5 South), Temple (PHR 7), San Antonio (PHR 8), El Paso (PHR 9/10), and Harlingen (PHR 11). TDH also operates two health care facilities, the Texas Center for Infectious Disease in San Antonio and South Texas Health Care System in Harlingen (see Table 3.5 below). In addition, TDH has full-time equivalents (FTEs) located in 36 Local Health Departments across the state.

Table 3.5 Staffing by Location

STAFFING LOCATIONS	TOTAL
Central Office – Austin	2,577
Region 1 – Lubbock	130
Region 2/3 – Arlington	284
Region 4/5 – Tyler	241
Region 6/5 – Houston	268
Region 7 – Temple	187
Region 8 – San Antonio	200
Region 9/10 – El Paso	202
Region 11 – Harlingen	326
South Texas HealthCare System	129
Texas Center for Infectious Disease	212
Local Health Departments	63
Other-Headquartered outside Austin	82
Total	4,901

Source: Texas Department of Health, Human Resource Information System

As outlined in the Appropriations Act, 77th Legislative Session, the Texas Department of Health was authorized 5,116.4 full-time equivalent (FTE) positions in support of six goals and 37 strategies committed to partnering with the people and communities of Texas to protect, promote and improve health. However, the number of actual filled positions will vary. To accomplish these goals, the agency has resources strategically located throughout Texas (see Table 3.5). On the next page is a breakdown of the number of human resources (staff, not expressed in FTEs) in each of the major areas.

Table 3.6 provides a breakdown by race depicting the diversity of the agency by program units and includes the two health care facilities. Table 3.7 provides a summary of the workforce by gender (male and female) for each major program, regional area and health care centers.

Table 3.6 Workforce by Race

Program Area	Ameri Indian/ Alaska Native	Asian/Pacific Islander	Black	Hispanic	White	Total
Commissioner's Staff	0	2	21	26	135	184
CFO's Staff	0	4	23	29	119	175
Information Systems	1	13	8	19	98	139
Operational Support		2	50	47	127	226
Disease Cont & Preven	3	45	94	146	490	778
Family Health	3	16	56	117	372	564
Consumer Health	3	11	85	96	406	601
Public Health Region 1	1	0	8	31	91	131
Public Health Region 2/3	2	2	30	35	205	274
Public Health Region 4/5	0	0	39	14	188	241
Public Health Region 6/5	0	15	83	42	124	264
Public Health Region 7	0	1	9	30	140	180
Public Health Region 8	0	1	7	93	98	199
Public Health Region 9/10	0	2	5	124	69	200
Public Health Region 11	0	2	6	268	47	323
TCID	1	2	22	125	57	207
STHCS	0	2	0	109	21	132
Local Health Departments	0	1	10	24	27	62
Total	14	121	556	1375	2814	4880

Source: Texas Department of Health, Human Resource Information System

Table 3.7 Workforce by Gender

Program Area	Female	Male
Commissioner's Staff	113	73
CFO's Staff	122	53
Information Systems	63	76
Operational Support	96	130
Disease Cont & Prevention	515	263
Family Health	397	167
Consumer Health	402	199
Public Health Region 1	89	42
Public Health Region 2/3	193	81
Public Health Region 4/5	190	51
Public Health Region 6/5	195	69
Public Health Region 7	118	62
Public Health Region 8	119	80
Public Health Region 9/10	152	48
Public Health Region 11	233	90
TCID	138	69
STHCS	87	45
Local Health Departments	45	17
Total	3267	1615

Source: Texas Department of Health, Human Resource Information System

Human Resource Training Programs

The mission of the TDH Organization and Human Resource Development (OHRD) division is to assess, deliver, and evaluate learning and organizational development for TDH employees and the public health workforce.

OHRD assesses learning and staff development needs both formally and informally on an ongoing basis. We will conduct a formal, agency-wide needs assessment in 2002. This assessment consists of an employee survey, focus groups, and individual interviews. It targets every salary group in the agency: line staff, supervisors, managers and agency executives. The purpose of this assessment is to determine what training and learning opportunities TDH staff desire but that are not currently available.

Annually, every TDH employee participates in the Performance Journal process. One of the elements of a performance journal is the Learning Portfolio, which records the employees' training and development needs for the upcoming year. This data is used by OHRD to determine future training calendars for future years. Based on the Learning Portfolios, three courses were added to the training calendar in 2001: Public Speaking, Business Writing Skills and Workplace Violence. Two courses that were conducted as a part of the Continuous Quality Improvement (CQI) effort are now offered to all employees: On Great Service and Emotional Intelligence. With the addition of these courses, we will teach over 200 classes in FY 2002. Human Resource Development presents a variety of training courses each month, such as: Franklin Covey's Seven Habits of Highly Effective People, Four Roles of Leadership, What Matters Most, Public Speaking, Enhancing Presentation Skills, Marketing Your Skills, Effective Supervision and Myers Briggs Type Indicator. In FY 2001, in the central office, we trained 192 supervisors and managers in Four Roles of Leadership and Effective Supervision, 120 participants in Enhancing Presentation Skills, 120 in Interview and Selection, 24 in Meetings in Motion, 48 in Myers Briggs Type Indicator, over 500 in New Employee Orientation, 36 in Orientation to Video Conferencing, 36 in Registrar Basics, 216 in Seven Habits of Highly Effective People and 144 in What Matters Most. Classes were also conducted monthly in the regional offices by the central office training staff.

OHRD conducted a Leadership Development Lab in 2001 and 2002 with 21 different 90-minute introductory classes based on results of the Survey of Organizational Excellence (SOE). Over 700 attendees participated. We will institute a Management Training Plan in 2002 based on the results of the Business Improvement Plan. An additional change is that by May 2002, the New Employee Orientation will be presented in a largely computer-based format.

Course evaluations are accomplished by two methods. First, every participant in every class is asked to evaluate the training according to effectiveness, teaching methodology, curriculum, and potential impact on

their jobs. Second, the registrar database automatically sends acknowledgement of successful course completion to each participant and asks for additional comments.

Effective September 1, 2002, Human Resource Development will be consolidated with HHS agencies into one central training department to effectively and efficiently provide services to staff in individual agencies, using the existing staff from HHS agencies, resulting in cost savings. This will expand the availability and consistency of administrative training within the HHS enterprise and promote use of current agency best practices, including technology-based training and vendor based training, in the delivery of administrative training.

The UT Survey of Organizational Excellence

The University of Texas (UT) School of Social Work offers an opportunity every two years for Texas state agencies to participate in the Survey of Organizational Excellence (SOE). This survey provides a uniform benchmark for all Texas government agencies to compare employee perceptions of organizational functions, strengths and weaknesses. The most recent iteration of the SOE was conducted at TDH between December 3, 2001 and January 11, 2002. The response rate at TDH was 58 percent, an increase of 49 percent over the last survey's rate (January 2000). Table 3.8 presents SOE areas of strength and concern for TDH.

TDH management is committed to a more vigorous response to the SOE results in 2002, and as of this writing, is reviewing the response data and a draft implementation plan. The implementation plan outlines steps the agency will take to:

- Validate the survey results (through focus groups);
- Communicate the results to staff (via online data, interactive town hall meetings with the Commissioner, and newsletter articles); and
- Establish expectations and processes for Associate Commissioners, Regional Directors, and Health Care Facility Directors to address issues identified for their respective Bureaus and/or staff.

The timeline proposed in the implementation plan begins with validating the results and then proceeding with the other implementation steps to be carried through until January 2003. The implementation plan and related activities will be closely coordinated to assure compliance with the Business Improvement Plan for the agency.

Table 3.8 Highest and Lowest Ratings from the Survey of Organizational Excellence

Areas of Relative Strength: 5 Highest Scoring Constructs	Average TDH Rating (based on 100-500 scale)
1. Quality: The degree to which quality principles, such as customer service and continuous improvement, are a part of the agency culture. The extent to which employees feel they have the resources to deliver quality services.	368
2. Strategic: How the agency responds to external influences that should play a role in defining the agency's mission, vision, services, and products. The ability of the agency to seek out and work with relevant external entities.	364
3. Benefits: Comparable benefits that employees feel exist with other organizations in the area.	361
4. External: How information flows into the agency from external sources; how information flows from inside the agency to external constituents. The ability of agency staff to synthesize and apply external information to work performed by the agency.	350
5. Burnout Factor: Extreme mental exhaustion negatively impacting employees' physical health & job performance, leading to lost agency resources & opportunities. For consistency with other constructs, higher scores represent a lower level of perceived burnout.	345
Areas of Concern: 5 Lowest Scoring Constructs	Average TDH Rating (based on 100-500 scale)
1. Fair Pay: The overall compensation package offered by the agency; how well the package 'holds up' when employees compare it to similar jobs in other organizations.	215
2. Internal Communications: The flow of communication within the agency from the top down, bottom up, and across divisions or departments. The extent to which communication is open, candid, and moves the agency toward goal achievement.	293
3. Supervisor Effectiveness: The nature of supervisory relationships in the agency, including quality of communication, leadership, thoroughness and fairness that employees perceive exists between supervisors and them.	312
4. Team Effectiveness: The people within the agency that employees work with on a daily basis to do their jobs. How effective employees think their work group is, and how the agency environment supports cooperation among employees.	312
5. Change Oriented: The agency's capability/readiness to change based on new information & ideas. The agency's aptitude to process timely information and act upon it effectively. The agency's capacity to develop & use strengths of all agency staff for improvement.	318

Source: "Survey of Organizational Excellence," University of Texas at Austin.

Prepared by: Division of Organizational and Human Resources Development, Department of Health.

Interagency Planning For the HHS Enterprise

All 11 Health and Human Services (HHS) agencies participated in development of the *2003-2008 HHS Coordinated Strategic Plan (CSP)*, which continues to focus on ways to redesign and integrate services across agencies. The agencies obtained consumer input by using an integrated planning process that included community planning forums and a variety of agency consumer activities. The agencies then analyzed the input and developed specific goals, objectives and enterprise strategies that require interagency cooperation and coordination.

The enterprise strategies are the link between the agency strategic plans and the *CSP*. All HHS agencies are directly involved in five of the enterprise strategies and have the responsibility for determining which other enterprise strategies benefit their stakeholders and require direct agency involvement. Direct involvement means the agency has: 1) targeted resources towards achievement of the enterprise strategy; and/or 2) incorporated the enterprise strategy into their agency strategic plan and annual operating plan. In addition, each HHS agency identified further enterprise strategies to address.

Beginning in FY2003, agencies will report their progress towards achieving the enterprise strategies and incorporate relevant strategies and activities into their annual operating plans.

The enterprise strategies for the *2003-2008 HHS Coordinated Strategic Plan* and the specific strategies to which the Texas Department of Health will contribute (bolded) are:

- Promoting the Independence Plan;
- Services & Supports for Individuals with Long-term Care Needs;
- **Health & Self-sufficiency in Border Colonias;**
- **Information and Referral;**
- Eligibility, Enrollment & Navigation;
- **Recruitment & Retention of Service Providers;**
- **Transportation Services;**
- Regional Access Planning;
- **Children & Youth with Complex Needs;**
- **Adults with Complex Needs;**
- Caregiver Support;
- **Operational Efficiencies;** and
- **HHS Workforce Issues.**

The CSP structure, as well as detailed descriptions of the enterprise strategies and TDH related strategies, are provided in Appendix H.

